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HAMILTON PSYCHIATRIC HOSPITAL

1993 Annual Report

COMMUNITY ADVISORY BOARD

PEOPLE, PLANNING AND ACTION

HAMILTON PSYCHIATRIC HOSPITAL

Dedication

This annual report is dedicated to Hamilton Psychiatric Hospital's employees and volunteers.

We are partners. Your creativity, energy, and talent produce better lives for the people we serve and will continue to be crucial into the future.

In a year that has brought great political, social and economic change to each and every one of us, you have kept the HPH mission: "To work together with adults with severe psychiatric disorders, their families and their communities to achieve successful treatment, rehabilitation and reintegration" foremost in all that you do.

Thank you.

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"Consumer"

is the recognized term developed by advocacy groups in Ontario to describe a person with a mental illness.

MESSAGE FROM THE Chairperson AND Administrator

Canada's health care system has been in transition almost from the very beginning, when universally accessible, affordable and comprehensive medical and hospital care became part of the very fabric of Canadian life.

In 1993, Ontario felt the full brunt of reductions in revenue due to economic change. HPH and other service organizations had to cope with more rapid change in the levels of funding and in the ways it operates, than ever before. While it was unfortunate that such intense and rapid change resulted in adding stress for everyone—staff, patients and families certainly felt the uncertainties of change—we were fortunate to have completed our strategic plan.

Amidst the sometimes chaotic atmosphere caused by changes in legislation and funding, the social contract, and other events, we are able to look to our strategic plan for assurance that HPH does, indeed, have a well-defined future and strategies which focus on moving forward.

We were pleased to receive the endorsement of our strategic plan from our district health council planning partners and approval from the Ministry of Health.

The strategic plan sets out a number of strategies, which link our specialized programs to service delivery, to achieve the very clearly articulated goals in our mission statement.

As outlined in the plan, all of our efforts over the next five years will be devoted to reversing the 100-year-old history of so many people being referred to HPH who end up living in Hamilton for the rest of their lives and not in their own communities. This phenomenon developed for a number of reasons, not the least of which was the fact that community support programs grew in close proximity to HPH and McMaster University.

Even in the best of economic times, this process of change would be slow. We must be patient to avoid the disruption of the excellent services which are already in place.

We do not want anyone to "live" at HPH. To aid the transition, our highly-skilled staff who have dedicated their careers to the very special people we serve, will be available wherever they are needed, at the hospital or in the community. We are striving to ensure that we provide all consumers with an opportunity to live in their home communities, with the appropriate supports, so they have the potential to improve their quality of life.

Just as we finished our strategic plan, the Province of Ontario published a major policy paper called *Putting People First: The Reform of Mental Health Services in Ontario.* The major objectives in this provincial plan have already been implemented, or are planned for implementation in HPH's own strategic plan. For example, the goal of the provincial plan is to reduce reliance on inpatient services, so that in 10 years the provincial average of beds set up in both general hospital psychiatric units and specialty psychiatric hospitals, such as HPH, will be 30 per 100,000 population. We have almost reached that goal (34.7 beds per 100,000) in the referral areas of HPH.

Reform will also shift funding and serv

ices so that more community-based (non-institutional) services are available in the future. Again, HPH has a 20-year history of providing community-based services in partnership with others, and our strategic plan calls for the acceleration of this shift as time and resources permit.

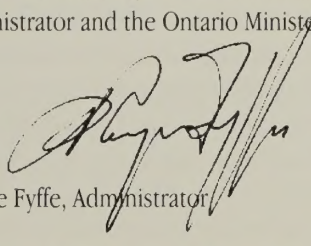
The Community Advisory Board said goodbye to some valued members whose maximum six-year term expired in 1993. Past chairperson Doug McAuley, and members Dr. John Lavery and Neil Pauls will be missed, but we know that they will continue to advocate for the improved quality of life for the consumers we serve.

We were very fortunate to welcome these new board members, who are active in their pursuit of our mission and bring new ideas to the hospital: From Niagara, Selina Volpatti and Dan Oettinger; from Hamilton, Richard Grigg, Richard Higgins and Beverly Moore, and, from Halton, Dierk Lange. The board continues to advise the administrator and the Ontario Minister of Health on the future of HPH and on proposals for change from the perspective of the consumers, families and general public in the communities they represent.

We continue to be optimistic about the future, with the assurance of continued support from our excellent staff, volunteers, board members, consumers and our community partners in service delivery.

We hope you will learn more about us in the pages that follow. As always, we welcome your comments and advice.

Larry Thibideau, Chairperson



Wayne Fyffe, Administrator

HPH Community Advisory Board

The purpose of the Community Advisory Board shall be to promote community awareness and understanding of mental health issues, identify and respond to the mental health care needs of the communities the hospital serves, and assist the administrator in providing the highest possible standard of care to the patients of Hamilton Psychiatric Hospital by:

1. Establishing and maintaining a close working relationship with all agencies providing services for the mentally ill;
2. Co-operating and consulting with district health councils and other planning groups;
3. Consolidating information on local mental health needs and concerns, and identifying those which the hospital should address;
4. Fostering the development of community relations in the areas served by the hospital;
5. Reviewing and monitoring the hospital's programs in order to determine whether the hospital is meeting the needs of its catchment area; and,
6. Advising the Minister of Health on important issues which may affect the hospital in fulfilling its mandate to provide high quality mental health services to the regions it serves.

HPH COMMUNITY ADVISORY BOARD

(first row, l-r): Wayne Fyffe,* Carol Gooding, Ruth O'Donnell, Dianne Smithson; (back row, l-r): Beverly Moore, Susan Voss, Dr. Glenn Watson, Larry Thibideau, Dierk Lange.
(* ex-officio)

Reintegration

"We see an Ontario in which people live longer in good health, and disease and disability are progressively reduced. We see people empowered to realize their full potential through a safe, non-violent environment, adequate income, housing, food, and education, and a valued role to play in family, work and the community. We see people having equitable access to affordable and appropriate health care regardless of geography, income, age, gender or cultural background. Finally, we see everyone working together to achieve better health for all."

We agree with the vision of health for Ontario as set out by the Premier's Council on Health Strategy. This vision is now guiding the reform of the entire heath care system, including mental health reform.

We're also proud of our own record in furthering attempts at reintegration even before the Government of Ontario published *Putting People First*, its official mental health reform policy, in 1993. In fact, HPH started developing and delivering services in the communities of its consumers as far back as 1973. So, when the government targeted 30 psychiatric beds per 100,000 citizens to be achieved by psychiatric hospitals and general hospital psychiatry units by the year 2003, HPH was nearly there. The total number of beds for the five regions we serve, including those designated at HPH, has brought us to 34.7 per 100,000. It's the lowest rate in Ontario.

How have we achieved these goals?

As we mentioned, well before mental health reform was being planned, HPH began taking a proactive role in developing community programming for people with psychiatric disorders as close to their homes as possible. In partnership with the five regions we serve, HPH has and continues to pilot psychiatric treatment and rehabilitation programs in the heart of our communities. HPH provides consultation to community health care providers in areas of HPH expertise. We also assign full-time staff to community treatment programs and clinics to facilitate the sharing of psychiatric expertise, and to ensure our former consumers receive the continuity of care so vital in making that effective transition from hospital to home.

All of our clinical services, as well as our Educational Services and Public Relations departments, strive to educate consumers, families, affiliated health care professionals and the public about the diseases we treat, the impact they have on consumers and families, and about the management and treatment issues involved. These services are delivered independently by HPH or in partnership with others. Our volunteers, too, are vital in helping consumers cross the bridge from hospital to home by acting as their most dedicated advocates.

Teaching and research is important. HPH is formally affiliated with McMaster University, Mohawk College of Applied Arts and Technology and the World Health Organization. Not only do we keep teaching our skills and training to others, but we, too, keep learning so we can change with the changing needs of our consumers.

We are proud of our continuing efforts toward reintegration; obviously they are successful. Less than 20 long-term consumers reside at HPH now and all are working with highly-specialized staff to ensure their reintegration when they are ready.

Now that the concept of reintegration has been so successfully entrenched at HPH, it's time to rededicate our efforts to promoting the maintenance of wellness within our communities. We will continue to develop collaborative projects within our regional boundaries to reach consumers who need our assistance where they live. We will improve the number and range of community consultations to help prevent rehospitalization.

We plan to expand the range and role of our Homes for Special Care and support the development of various housing options. Vocational opportunities, too, will be increased; again, with the full participation of consumers, agencies and other ministries to ensure goals are in line with those of our consumers and their communities.

Planning and action are for nothing, though, if the right people aren't involved. To HPH, the "right" people are our own staff, who have the skills, knowledge, and dedication necessary to help implement a more comprehensive system of services and supports.

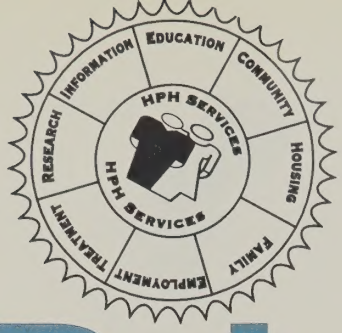
And there's another group of "right" people. They are the consumers we know, the ones we don't and the ones we hope we never have to meet. By enhancing our working relationships, by understanding their needs as people and not just as "consumers," we will build a solid foundation for a more empowered and healthier population of tomorrow.

HPH STAFF WORKING FULL-TIME AT AFFILIATED ORGANIZATIONS:

- Adult Mental Health Services, Haldimand-Norfolk
- Chedoke-McMaster Hospitals
  - Outpatient Psychiatry
- HARP Ceramics and Gifts
- St. Joseph's Hospital (Hamilton)
  - East Region Mental Health Services
  - Emergency Psychiatry Service
  - Community Psychiatry Service
- Wellington Psychiatric Outreach Program

HPH STAFF ALSO PROVIDE COMMUNITY SERVICES AND/OR CONSULTATIONS. A PARTIAL LIST OF OUR COMMUNITY LOCATIONS AND/OR SERVICES INCLUDE:

- Brant County Geriatric Mental Health Outreach Program
- Brantford General Hospital
- Christian Latvian Evangelical Lutheran Church Centre
- Community Housing Co-ordination Service
- Community Long Term Care Program
- Educational Services
- Exit Team
- Forensic consultations
- Geriatric Psychiatry Community Team
- Greater Niagara General Hospital
- Hamilton-Wentworth Board of Education
- Health Education and Learning for the Handicapped Service
- Joseph Brant Memorial Hospital
- Mood Disorders Clinic, Outpatient Psychiatry, Chedoke-McMaster Hospitals
- M.R./Dual Diagnosis Outreach Team
- M.R./Dual Diagnosis Transition Team
- Oakville-Trafalgar Memorial Hospital
- Pastoral visits to hospitals, lodging and nursing homes
- Psychiatric Education Program
- Public Relations
- Schizophrenia Intensive Treatment Program: Bridge to Discharge
- Schizophrenia Psychosocial Rehabilitation Program: The Annex
- Special Clinics
- St. Catharines General Hospital
- Vocational Services
- Welland County General Hospital



Rehabilitation

In 1989, the Ontario Ministry of Health conducted an operational review of all the vocational programs operating in the provincial psychiatric hospitals. From that review came *the Phillips Report* and two strong recommendations: that 50 percent of a psychiatric hospital's patients in vocational programs be placed in alternative, community-based training, supported employment and employment programs by 1995, and, that each psychiatric hospital incorporate the principles of psychosocial rehabilitation (PSR) throughout its organization.

We took the recommendations very seriously.

In 1993, HPH adopted the following definition of rehabilitation:

Rehabilitation with adults with severe mental disorders focuses on helping the individual develop, improve and maintain skills necessary to live in the community of choice with the least amount of support necessary. The approach, based on psychosocial rehabilitation principles, includes the concept of hope, modification of the environment, use of supports and/or resources for as long as necessary, and is activity-based.

Hospital-wide, we formally adopted the principles of PSR, which embrace these concepts: consumer-involved, community-focused, individualized service, comprehensive range of service, importance of environment, full accessibility, activity-oriented, a committed staff, accountability and effectiveness.

At HPH, we believe that rehabilitation involves everyone. PSR principles and traditional treatment models are not mutually exclusive. Rather, PSR principles can and should be reflected in the treatment model adopted by any particular program.

Extensive staff training has already occurred in the Schizophrenia Psychosocial Rehabilitation Program and within the Rehabilitation Services Department. At the community level, education and rehabilitation professionals from HPH have worked closely with Mohawk College of Applied Arts and Technology to assist in its development of a course devoted exclusively to the clinical implementation of PSR.

Across HPH, consumer involvement is encouraged and facilitated at all levels of planning and evaluation. We're proud of our staff, who have willingly and consistently sought the opinions of their consumers long before this concept was formally adopted—because they knew it was the right thing to do.

Indeed, we've witnessed a momentum sweep through the hospital, resulting in more consumer-directed support groups and "community meetings" taking place between staff and consumers on the units, an increase in consumer membership overall on hospital-wide committees in areas such as Strategic Planning, Fiscal Advisory and Public Relations. More literature is appearing to help consumers and families understand our services, either at the hospital or in the community, and it's being written with their point of view in mind. The Hamilton-Wentworth Mental Health Rights Coalition is actively supported by the hospital, which generously provides the coalition with office space and other resources. Staff, too, willingly assist the coalition in achieving its goals of advocacy and education by acting as educational

resources, speakers, and liaisons to provide consumers with links to other services.

If the principles of PSR mean empowerment for consumers, they can mean empowerment for staff, too. Nowhere has that been shown more clearly than within our Rehabilitation Services Department, whose staff were among the first to break down the traditional barriers that hampered consumer empowerment and understand that PSR is as much about creative license as it is about action.

The department is just beginning the process of totally re-engineering Beckfield Enterprises from an on-site vocational workshop, traditionally employing over 100 outpatients for assembly and packaging work in a sheltered setting, to a hands-on, skills development centre for inpatients or outpatients who wish to learn computer and word processing skills. Instead of being the end goal for many consumers—as the workshop used to be—it will now become one more step in the transition to community.

Which is what has happened precisely to another HPH enterprise called HARP Ceramics and Gifts. At one time a sheltered workshop for outpatients, specializing in the production of ceramics, the renamed HARP Ceramics and Gifts has, with the assistance of staff and consumers alike, been transformed into a community-based, affirmative enterprise. HARP threw open its doors for business in January. It now has 35 employees (including three HPH staff), a board of directors, and a Consumer Advisory Committee: together, all are working hard to achieve HARP's objective to turn into a full profit-sharing enterprise within two years.

As our workshops have downsized, our staff has taken advantage of the opportunity to follow consumers into the community. For example, the department's program of Training Placements and Supported Employment has now expanded to 50 positions in the community. Our Vocational Services staff find our consumers work in a variety of businesses across the five regions HPH serves, and vocational instructors provide coaching and other supports on-the-job.

This new year promises still more change; again, all consumer-centred and community-based. Discussions are taking place about the role of occupational therapists and how their work can evolve to include home assessments. Recreationists, too, will investigate even more ways to assist outpatients explore the total range of leisure activities open to them in their community.

A lot is clinical judgement, a lot is common sense; whatever the mix, rehabilitation at HPH will continue to mean a full range of choices with the support and guidance needed to help people make the life decision that's right for them.

Acquired Brain Injury

Holding back tears, the newly-appointed associate minister of health recalled how her own brother recovered from the brain injury he sustained in an accident.

It was a dramatic moment for HPH, and one that underscored the importance of the event, as MPP Shelley Wark-Martyn was speaking to an audience of 200 gathered at the hospital's ground-breaking ceremony for its new Acquired Brain Injury (ABI) Program. The ceremony marked the start of construction of a 10-bed, $900,000 residence for consumers.

Three years in the planning—and one of the first of its kind in Canada—the program is a trendsetter. It provides consultation, assessment, treatment planning, therapeutic services and follow-up support to medically stable consumers with severe behavior problems resulting from an acquired brain injury.

Since the ground-breaking, both the program and its residence have developed quickly. Early in 1993, the program accepted several consumers but had to offer treatment in other areas of HPH until the residence was built. It officially opened its doors in January, 1994. Now, the program's entire facilities include: clinical offices, the 10-bed residence which provides consumers with a practical learning environment integrated with a home-like design, and a treatment centre, which includes classrooms, exercise rooms, and a vocational centre.

The program consists of a short-term inpatient assessment, individual treatment plans, community placement and follow-up. Discharge planning starts at the front door; that is, as soon as a person is accepted. All rehabilitation efforts are consumer—not program—directed. They are designed to help a person progress toward the most independent living arrangement possible, one which reflects the person's own goals and aspirations. Average length of stay is expected to take between three and 16 months.

All of the behavioral and medical treatment rest upon this foundation: the commitment to provide the least intrusive but most effective treatment possible. Treatment must respect basic human rights, including the right to privacy, the right to receive the most effective treatment, and the right to services which are driven by the goal of personal welfare.

The team approach is a new one for HPH: it's transdisciplinary. One person—the prime therapist—is responsible for all aspects of the consumer's program. The "prime" is a health professional who may come from any discipline as long as he or she has expertise in behavior analysis. In addition, the transdisciplinary model focuses more on generalization issues and allows for the cross-over of treatment amongst staff from a variety of disciplines.

The rehabilitation model is based on applied behavioral analysis, in which the goals are to decrease inappropriate behaviors and increase skills.

The program is being developed as a provincial resource in association with McMaster University, Faculty of Health Sciences, as an international centre of excellence which will provide exceptional opportunities in applied clinical, research, training and teaching. It will serve as a pilot to be evaluated for replication in other centres across Ontario.

Research includes: examination of prevention strategies, early intervention issues, treatment issues (such as the development and validation of assessment tools), systematic replication of the use of behavior change procedures, learning issues, behavioral treatment of memory issues and the examination of personal stimulus control, and the effectiveness of the prime therapist model versus the traditional team approach.

With this program, consumers will undergo treatment in a home-like atmosphere and remain as close to their home community as possible. That proves beneficial to their ability to progress, allowing them to retain what they learn and move on. We hope readmission will be rare.

Affective Disorders

Affective disorders, which include clinical depression, manic depression and seasonal affective disorders (or "winter" depression), strike 15 in every 100 Canadians. The rapid growth of the size and services of the Affective Disorders Program at HPH underscores the community's growing recognition that affective disorders are, in fact, biochemically-based diseases which cannot be prevented by the person they attack. Originally launched as an eight-bed unit, the program now encompasses a 32-bed inpatient unit, an extensive outpatient unit, a satellite clinic at Chedoke-McMaster Hospitals and a consultation service for doctors working within the hospital's five referral regions.

While medication is a significant part of the treatment, staff on the Affective Disorders Program believe understanding a disorder is a key tool for coping. They work hard to ensure that education plays a primary emphasis on the program. Individual sessions are conducted for consumers and their families about the illness, treatments, coping skills and community resources and a formal, four session evening program is run twice a year for the same group.

Some 200 consumers visit the program's outpatient unit every year. It's the largest clinic of its kind in Hamilton-Wentworth and the only one fully dedicated to dealing with depressive illness. The focus of the outpatient unit is to maintain people on a stable course. That goal is accomplished through medication monitoring and through discussion and early resolution of other problems. Like the inpatient clinic, outpatient staff will refer consumers, when necessary, to the hospitals' other services or to other community resources, like the Chedoke-McMaster Family Centre or its Mood Disorders Clinic.

The program continues to focus its research activities on innovative new treatments. Seasonal depression—which causes people to become depressed from the lack of light from September to April—is now commonly being treated through a daily program of intense light treatment. Every year, staff actively promote the program through the local media in an effort to help people recognize symptoms and to make them aware that help is readily available. In fact, to increase community access to treatment, the light therapy program was made available on a self-referral basis in 1993.

Major research initiatives for the program continue: the evaluation and treatment of refractory depression, the evaluation and treatment of refractory manic-depressive disorders, and the development of standards for the care of affective disorders in the community.

As the quality and quantity of medications used to treat affective disorders has improved over the years, the number of electroconvulsive therapy treatments has diminished. Consequently, to improve the efficiency of care provided to the whole community, HPH and St. Joseph's Hospital in Hamilton agreed to centralize all such treatment at St. Joseph's. This initiative will take place in 1994.

Staff continue to promote awareness and education by providing workshops to community agencies, by running an intensive affective disorders course for hospital and community health care workers, and by offering medical education to family physicians and educational resources to local consumer and family support groups on a regular basis. In addition, HPH is committed to help the communities it serves examine their capacity to jointly develop community-based clinics similar to the satellite clinic currently operating in Hamilton.

Assessment

In 1989, HPH reorganized its programs to reflect the diagnostic-specific needs of its consumers. Two generalist programs had to remain: the Assessment Program, responsible for the assessment and triage of emergency admissions from Hamilton-Wentworth, and the Community Liaison Program, which provided assessment, treatment and rehabilitation for admissions coming in from the hospital's other four referral regions.

Why the difference?

In Hamilton-Wentworth, proportionally fewer general hospital psychiatry beds exist because HPH is located within the region. Because HPH is based within its borders, Hamilton-Wentworth has developed more supportive housing and community programming for the many consumers discharged from HPH.

Conversely, the other regions developed more general hospital psychiatry beds (because the inpatient beds at HPH were so far away) but fewer residential and community services. The exception is Haldimand, which still does not have an inpatient psychiatric unit.

Therefore, consumers are often directly admitted to HPH from the region's Emergency Psychiatry Services (located at St. Joseph's Hospital in Hamilton), while, for the most part, consumers from the four other regions HPH serves are referred by general hospital psychiatry inpatient units.

The resources they need in their communities are now being built, thanks to a variety of sources. Even before the advent of mental health reform, dedicated people across these regions have been working to develop a more responsive and co-ordinated system of care. The province's policy on mental health reform has now served to spur on that very positive shift in attitude towards the needs of psychiatric consumers.

We credit our Community Liaison staff for their dedication in helping to spearhead that reform. Five staff members have been working directly in those four regions, providing assessments in the community, consultations to community health services providers and, most important, dedicating their time to consumers and families to provide a seamless transition from admission to the unit to reintegration home.

By improving the communication channels between HPH and community resources, referral agencies, consumers and families, the program has found that even the limited time the community workers spend in the field has significantly reduced the need for inpatient beds. Even the types of referrals have become more appropriate for such a specialized facility.

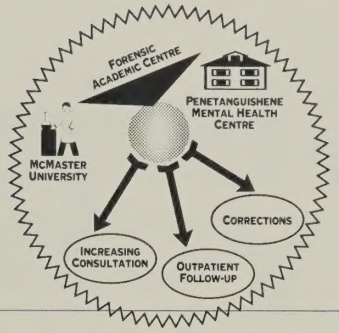
Therefore, HPH has been vigorously planning to ensure these two assessment programs change with the needs of their consumers and the communities in which they reside. Not every consumer fits into a clear diagnostic group; certainly a definite demand remains for a generic assessment program to help sort and manage those very difficult diagnostic and assessment situations.

But do we need to continue two separate inpatient units with 45 beds between them? Our studies indicate that we don't. In 1994, we plan to integrate the two units, under the name of the Assessment Program, and provide a 24 to 30 bed assessment, short-term treatment and referral service for all five of the regions we serve.

We believe that what we reduce in numbers, we will regain in efficiency. The Assessment Program will become the only unit to provide general experience in HPH and, as such, will be converted into the hospital's principal teaching unit. Renovations will take place over the next year to accommodate the impact of this change.

Our outreach activities and community integration services will continue. It is our hope that as the number of beds decrease, we will be able to expand our community outreach activities. As well, we will examine plans to develop a Rapid Response Team, based at St. Joseph's Hospital in Hamilton and linked to the region's Emergency Psychiatry Services there. The team would function as a mobile unit. With two holding beds, it would be mandated to immediately determine the needs of a consumer in crisis and provide solutions for those needs as an alternative to hospitalization.

Forensic



Movie clichés aside, people who have a mental illness are no more dangerous to our society than any other group. But there's no doubt about it; a small number of people with chronic and acute mental illnesses, when left untreated, will sometimes transgress our civil and criminal codes.

About 40 percent of the approximately 200 inpatients at HPH are involuntary. They have been committed through health services or concerned family members acting under stringent procedures laid down by the Ontario Mental Health Act. Less than 10 percent of those inpatients are undergoing assessments for mental competency or are in treatment because they have committed a crime—usually a trespassing or nuisance crime due to impaired judgement caused by a mental illness. There are some who, a very long time ago, committed a more serious crime and have been treated at maximum and medium-secure psychiatric hospitals and, after showing compliance with their treatment and rehabilitation goals, have been transferred to HPH.

The Forensic Program at HPH assists the judicial system in determining the mental state of a person accused of committing a criminal act. Its main functions are: the performance of court-ordered psychiatric assessments, the treatment and rehabilitation of individuals who have been remanded by the courts and are awaiting Ontario Criminal Code Review Board hearings, and, the treatment of mentally disordered offenders where psychiatric hospitalization is required.

Because the eight-bed program offers minimum security only, it has traditionally refused to admit persons charged with sexual assault, murder or arson. The escape of such persons could pose a risk to public safety. Therefore, they are sent for assessments to the medium or maximum-secure units of other psychiatric hospitals across the province.

However, for the first time in 10 years, a potentially dangerous offender did escape from the hospital and tried to commit an assault in the community.

That incident, combined with recent amendments to Canada's Criminal Code which have significantly increased the number and legal complexity of referrals to HPH, has resulted in a host of changes both to the physical environment of the unit and to the way Forensic delivers its services.

Due to the heightened demand for Forensic's services, the program will move to a unit of its own (previously it had shared a unit) and expand its capacity to 18 beds. A second psychiatrist will join the team, and more stringent security measures are being added: the unit will be locked at all times, protocols to control traffic to and from the unit will be enacted, and additional improvements to the unit's physical security will be made.

Community outreach is being implemented and, that, too, will ensure those persons who should stay in a correctional facility will do so. A proposed pilot program would see Forensic staff carry out assessments in jail in the cases of individuals who obviously don't need hospitalization. The Ontario Ministry of Health has also strengthened its own guidelines to enable an immediate transfer of patients from a correctional facility to the most appropriately secure psychiatric facility, eliminating the need for "layovers" at HPH before a transfer to a more secure facility.

True to the spirit of Mental Health Reform, the inhospital treatment and rehabilitation programs established for people with an acute and chronic psychotic disorder—those who are the "true" forensic patients—are now being provided to those people in the community on an outpatient follow-up basis. As well, the team is providing increasing consultation services, within HPH and to the local hospital network.

The Forensic Program's role as a centre for education and research is being strengthened. A proposal currently before the Ontario Ministry of Health will affiliate the program with McMaster University and the Mental Health Centre of Penetanguishene to create a forensic academic centre with an emphasis on research and teaching. With plans to train competent people in the field of forensic psychiatry, HPH would become an information resource centre for the entire province.

Geriatric Psychiatry

At HPH, programs for geriatric psychiatry include a 34-bed inpatient unit, the Brant County Geriatric Mental Health Outreach Program and the Community Consultation Team. Their mission is to enhance community care for the elderly who have cognitive impairments and behavioral problems.

As the work of the geriatric outreach teams grow in sophistication and scope, the need for admissions to the inpatient unit will decrease and ultimately result in a unit which specializes in inpatient assessments and management for the most difficult behavior disturbances in dementia.

Budgetary measures and the impact of social contract days have had a toll on the inpatient unit. Still, staff are managing not only to maintain the standards of consumer care on the unit but to plan for improvements. The unit boasts a new therapeutic art program and two new activity centres. And, as the demands of the consumer population changes, so must the physical environment. Renovations are being contemplated which would split the unit into two so that older, more fragile consumers who need a dedicated geriatric environment will be separated from younger, more physically active consumers who require management of their behavior disturbances which result from dementia.

Not surprisingly, in hindsight, the population on the unit is becoming younger. Consequently, it has developed a particular interest and expertise in Pick's Disease—an early onset dementia. In fact, HPH plans to play a leading role in establishing a nation-wide database for such atypical dementias.

Depending on the outcome of the province's long term care reform, the inpatient component could eventually be reduced to approximately 20 beds. The savings from this reduction would be reallocated to the community to enhance the already very successful outreach services the program provides to the HPH referral area.

In the meantime, the model for the highly successful Brant County Geriatric Mental Health Outreach Program is planned as a joint venture with the region of Niagara. Since the Brant program's start in 1991, its staff have worked with over 300 consumers. Not one has been re-admitted to HPH. Its goal is simple: to improve life for elderly people who have late onset mental health disorders by helping them and their caregivers manage their care at home—wherever home may be. What makes the Brant program so effective is its combination of consumer care, caregiver resources and support, and community development.

The same purpose holds true for the program's Community Team: to keep people out of hospital and to maintain them in the community so that they don't need to be admitted to hospital. This team of self-described "troubleshooters" who formally specialize in assessment, treatment and rehabilitation cover all of the HPH referral areas with a special emphasis on Niagara. Last year, referrals to the team nearly doubled. Over the next few years, it will undergo a radical change as it helps implement the new outreach program in Niagara and redefines its services for the future.

Program staff are as equally committed to research as they are to education. Current studies include an environmental design suitable for people with dementia; the measurement of morale in geriatric consumers; the effectiveness of background music as therapy; the use of psychiatric drugs by consumers referred by community agencies and the reliability of the London Psychogeriatric Rating Scale as a way of measuring functional levels in different institutions.

M.R./Dual Diagnosis

Whenever possible, we believe people who have psychiatric disorders should receive assessment, treatment and follow-up services in their home communities to allow them to maintain their lives while managing their illnesses.

To assist HPH in reaching its mission, the work of the M.R./Dual Diagnosis Program has been intensified, both through its outreach and inpatient components. The adults in this program have a developmental delay together with a psychiatric or behavioral disorder.

While direct clinical service is important, we also believe that, to efficiently provide such specialized care, the communities we serve must first provide equitable access to primary and secondary care for this population. That care must be delivered with an understanding of their special needs and particular health vulnerabilities. Often, presentation of minor health problems become confused with their psychiatric diagnoses, resulting in what should have been a primary or secondary intervention turning into a tertiary care crisis. In other words, a hairline fracture shouldn't be confused with a psychiatric crisis because the consumer cannot communicate in the manner a front-line health care provider is accustomed.

Therefore, over the past year, our outreach team has continued its efforts to provide community-based assessment, treatment, follow-up and consultation in all of the hospital's referral regions. Now services are often initiated in the person's home community with follow-up and consultation continuing in the community.

For the inpatient unit, such change has brought new challenges. What was a 20-bed unit a year ago serving two consumer groups—acute and chronic—is now a 10-bed unit serving only the chronically ill.

This group posed a dilemma: they could not function successfully in the community after discharge, yet, while in hospital, their discharge objectives were not being met. Either they were unable to successfully leave or, if they did leave, they returned to hospital very quickly.

What they did need was creative, flexible programming, 24-hour support and wholly-dedicated resources to work with them one-on-one to discover whatever emotional or physical barriers exist which prevent their successful return to community living. They need staff who will do whatever it takes to help them and their other stakeholders overcome those barriers.

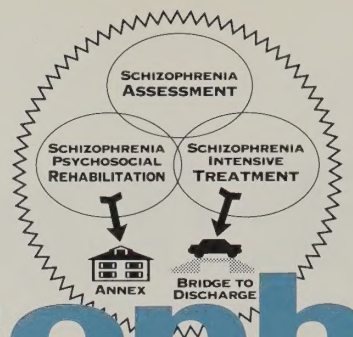
They needed a "Transition Team."

Based on the model of the highly-successful Exit Team, whose members have helped some of the hospital's longest-stay inpatients successfully achieve community reintegration, the Transition Team was developed to provide client-centred case management (using psychosocial principles); around-the-clock response mechanisms; inpatient, partial inpatient and outpatient care with the same staff member for each consumer; individualized assessment and treatment services, and, the ability to change services when consumers need change.

The work has just begun for the Transition Team and their consumers and it is intense. The process begins with an exhaustive assessment of personality, fears, needs, abilities, and responses to present and past events (any or all might present barriers to integration) to find the clues which will guide them through the barriers, and ultimately, to successful integration.

Once that goal is achieved, the hospital will examine the long-term focus of the program.

The key is trust. Given time, each consumer will learn as much about his staff person as that person knows about him. They will share new skills and new trials together, new problems and new solutions. The Transition Team's consumers will eventually learn that their team member will not leave them alone until they are confident they can look after themselves in their new living situation.



Schizophrenia

Like other programs at HPH, the three schizophrenia programs are increasingly focusing on people-centered—not program-centered—treatment models. The system and services are designed, shaped and targeted to meet consumer needs. Their services also reflect the broader indicators of health, such as supportive housing, income support, family involvement and employment opportunities. While available resources are limited, even greater attempts toward reintegration are being made by reallocating resources within these services.

The Schizophrenia Assessment Program functions as the doorway to the other two programs. Its main objectives are: to assess persons who have a provisional diagnosis of schizophrenia, to establish a definite diagnosis of schizophrenia, and to initiate or re-establish treatment. The goal is reintegration into the community with the necessary medical, social, family and occupational support as soon as it is realistically possible.

Over 100 consumers are treated on the assessment program annually, and they have an average stay of six to eight weeks. Up to 90 percent are discharged from the program directly into the community. Other consumers are transferred to other HPH programs or health facilities. During the past year, the program's team has continued strengthening links with outpatient programs and community agencies to develop services which function as a continuum of care for people with schizophrenia.

On the Schizophrenia Intensive Treatment Program, a new service called "Bridge To Discharge," is being developed. The pilot project is a collaborative project between the consumer-based Mental Health Rights Coalition, HPH and the Community Mental Health Promotion Program (CMHPP). It will assist in the building of therapeutic relationships with long-term inpatients to help them help themselves move into the community.

In fact, CMHPP and HPH are working together on the development of a pilot housing project with the Hamilton Housing Authority for the consumers who are participating in the Bridge To Discharge program. We expect that, during 1994, six consumers will be living in identified bachelor apartments with case management, based on the principles of psychosocial rehabilitation. The pilot phase of the project should require a two-year minimum timeframe.

The objective of the 30-bed intensive treatment program is to provide therapeutic management for difficult, chronic and unstable consumers. The program also runs a six-bed Adverse Drug Reaction Program (ADRP) to treat the most severe side effects caused by medications. In 1993, for the first time, a select group of inpatients was admitted to ADRP prior to discharge planning. Those consumers have had previous admissions and are readmitted because they abandoned their prescribed drug treatment and became unstable. Staff are now increasing their knowledge and understanding of how important compliance is with drug therapy and thus prevent or decrease further hospitalizations.

The Bridge To Discharge project is not dissimilar to The Annex project, developed on the initiative of our staff in the Schizophrenia Psychosocial Rehabilitation Program (SPRP) two years ago. In partnership with the Hamilton Housing Authority, our staff found eight bachelor apartments which are protected for their consumers. Each tenant has a bachelor apartment—a place to become independent in his or her own space yet live in one location for mutual support. A ninth unit is used for teaching. SPRP team members continue to remain involved with the tenants on a daily basis,

teaching, coaching and helping them practice life skills which they will need to take the next step—living on their own.

The Annex team received one of the Ministry of Health's first Quality Forum Awards for this unique initiative in 1993. The project has also been recognized in the provincial government's mental health reform policy, *Putting People First*, as a successful model for others to follow.

On the 30-bed inpatient unit, SPRP staff have experienced a very challenging year. The past year has seen a new consumer population with an average age of just under 40. They share a wide-range of skills, symptoms and dreams; yet all have serious difficulty functioning in the community. Consumers may stay on the unit as long as they need to and while there, they will participate in extensive assessments and program, hospital, and community activities, to learn the skills they require for successful community reintegration.

Staff on all three programs have made tremendous adjustments to the new service delivery models that must be used when implementing psychosocial rehabilitation principles to aid a consumer's transition to the community.

A strong network of case management already exists within Hamilton-Wentworth for people with acute and chronic schizophrenia. Key goals for improvement within the region will be: increased case management to reduce reliance on inpatient beds and enhanced emergency and rapid responses. For example, the HPH Century Manor Day Program, which offers a comprehensive rehabilitation and maintenance program for outpatients, is formulating a plan to move from HPH into the community next year.

In addition, HPH's schizophrenia services will begin to concentrate on the region's "disengaged population;" that is, those people with acute and chronic schizophrenia who can be found in hospital, jail, or living on the streets. As this population often "falls through the cracks," more service and treatment options for them may be pursued through an increase in outreach and case management.

1993
FINANCIAL STATISTICS

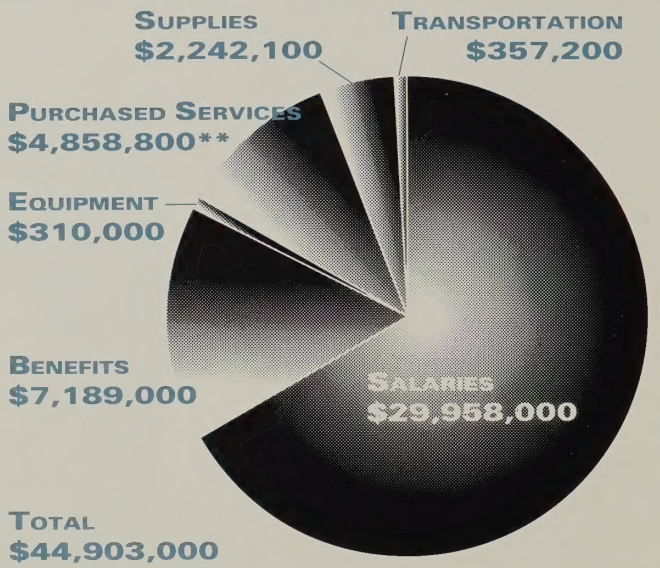
General Information*

	1990	1991	1992	1993
Beds Set up	322	287	287	245
Staff	736	735	716	697
Number of Admissions	945	849	861	728
Number of Discharges	952	849	861	776

* based on the 1993 calendar year

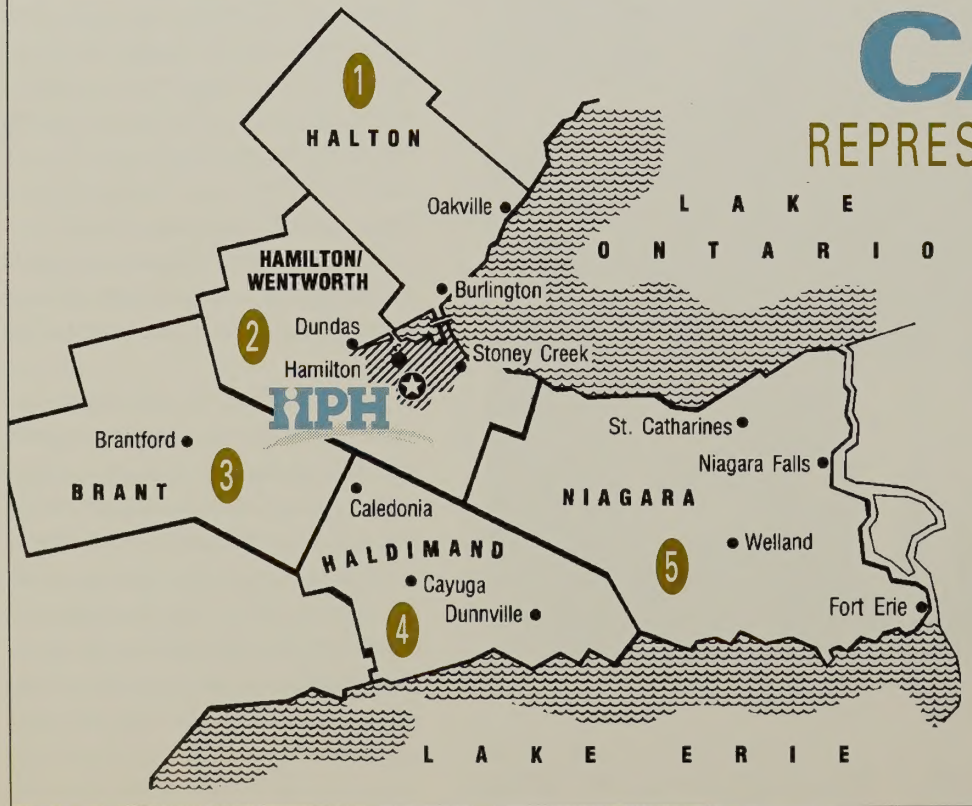
1993 /1994 Forecast
SUMMARY

Figures are based on projected actual for fiscal year ending March 31, 1994 and are expressed in thousands.



**Includes one-time funding of $800,000 for ABI Program building and construction.

CAB
REPRESENTATION



1 Carol Gooding
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3 Ruth O'Donnell
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4 Bernd Beilschmidt
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5 Daniel Oettinger
Selina Volpatti
Susan Voss

HAMILTON PSYCHIATRIC HOSPITAL

Mission Statement

OUR MISSION is to work together with adults with severe psychiatric disorders, their families and their communities to achieve successful treatment, rehabilitation and reintegration.

WE BELIEVE

- Each patient is a unique person.
- Each person has spiritual, cultural, mental, physical, social and economic needs which must be considered to achieve the potential for wellness.
- Our staff is our most vital resource, and they deserve a professionally-satisfying work environment which fosters learning.
- Care is an essential element of service to patients.
- Understanding of the disorders we treat and acceptance of the people affected by them will be achieved through education and advocacy.
- Collaborative planning with all hospital and community partners will ensure a comprehensive range of services offered as close to home as possible.
- Active research in diagnosis, treatment and rehabilitation, within HPH and in partnership with others, will ensure better care for the people we serve now and in the future.
- A high level of quality should be assured in all endeavours undertaken.

WE SERVE

HPH serves the five neighbouring Ontario regions of Brant, Haldimand, Halton, Hamilton-Wentworth and Niagara. Our patients are adults with severe psychiatric disorders who require specialized programs for:

- Schizophrenia,
- Affective disorders,
- Dementia with a major behavioral disorder,
- Developmental disability with a psychiatric or major behavioral disorder, and,
- Acquired brain injury with a psychiatric or major behavioral disorder.

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